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Original Articles.

MIRROR WRITING.

By GEORGE A. AUDEN, M.A., M.D.(Cantab.), M.R.C.P.(London).

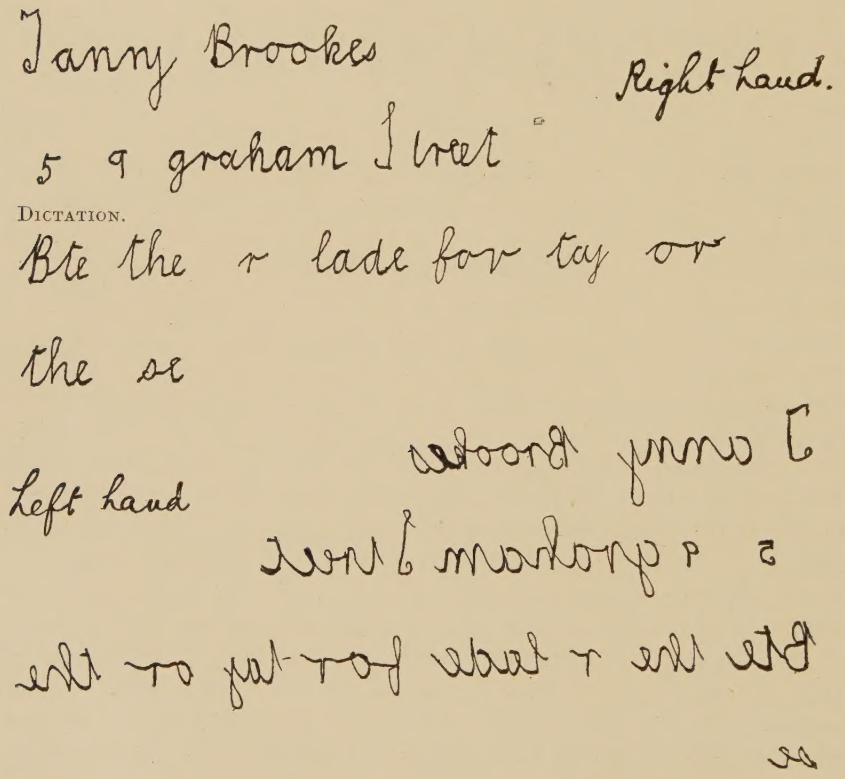
SPONTANEOUS retrograde or "mirror" writing is a phenomenon which is met with from time to time in children who are learning to write, and the chief interest of such cases lies in the psychological problems to which they give rise. The accompanying figure represents the writing of a girl, aged 10 years, who, from one cause or another, had received no school teaching whatever for over three years. When examined she was found to be able to name correctly the letters of the alphabet, but to be unable to read words of three letters. She could spell "cat,"* but not "dog" or "see." Her power of calculation for small numerals was of a normal character. On receiving a pencil she took it in her left hand and, without hesitation, wrote from right to left her name and the pseudonym "Baby." A fortnight after admission to school she was re-examined, and the results which were obtained with each hand are here depicted. She is quite unable to write to dictation,

* The word "cat" appears to be one of the easiest to memorise, and children with a considerable degree of mental deficiency are able to spell this word while unable to spell similar words such as "hat," "bat," etc. The combination of letters seems to form an easily memorised "graphic unity."

as will be seen in her attempt to write the words, "But there are lands far away over the sea," and the resulting letters point to a condition of paragraphia. Repeated examination revealed the interesting fact that the small addition and subtraction sums which she did were more frequently correct when she used her left hand than when she used her right hand.

What is the cause of this inversion of the normal process of

FIG. 1.



writing? With practice it is quite easy to acquire facility in "mirror" writing, and a little reflection and introspection will show that this facility is dependent upon an incitation of the visual centre and upon its connection with the cheiro-kinæsthetic or writing centre, for it will be found necessary to recall the visual picture of the shape of each letter before it can be formed with the pen. The term "centre" is here used not in the physiological and local sense, but rather as a convenient expression of the con-

ception of the psychological processes which take place in connection with the apperception of language and its concomitant associations.

The existence of a separate cheiro-kinæsthetic centre for the art of writing has been denied by some (*e.g.* Déjerine), but there seems to be adequate clinical and psychological argument in its favour as a definite entity. To quote the words of Dr. Bastian: "Just as the re-excitation of Broca's region under stimulation from the auditory word-centre is necessary for speech, so a re-excitation of the centre in which the impressions generated by writing movements are registered is, under stimulation from the visual word-centre, needful for the production of writing movements" ('Aphasia,' p. 101).

It must be borne in mind that the act of writing is one of the most complex muscular acts which is required of the hand, and that it necessitates the complete co-ordination of a large number of muscles. It is not, therefore, surprising that prolonged training is necessary before the handwriting becomes "formed," so that the caligraphy of many persons never loses its juvenile character.

The act of writing never becomes as automatic as does that of reading or speaking; for instance, while it is quite easy to read to the bottom of a page without having a definite idea of the words read or of their meaning, or to speak without any conscious choice of words, this is not the case with writing. In writing the cheiro-kinæsthetic centre requires the conscious guidance and re-inforcement of one of the other centres of the memory-complex. This is also true for the so-called "automatic writing" such as that produced by Mrs. Verrall, for in this case the writing centre is the agent of the subliminal consciousness ('Proc. Psych. Res. Soc.,' pt. liii).

It must also be remembered that the memory impressions stored in the writing centre are memories of *movement,* not of perception as are those of the visual and auditory centres. That there are potential kinæsthetic centres for writing on each side of the brain, as would be expected *à priori* from the association of the centre with muscular movements, seems to be rendered probable by the fact that persons who have lost the use of their right hand learn to write with the left, although never with that ease and celerity which the right hand had acquired from early training.

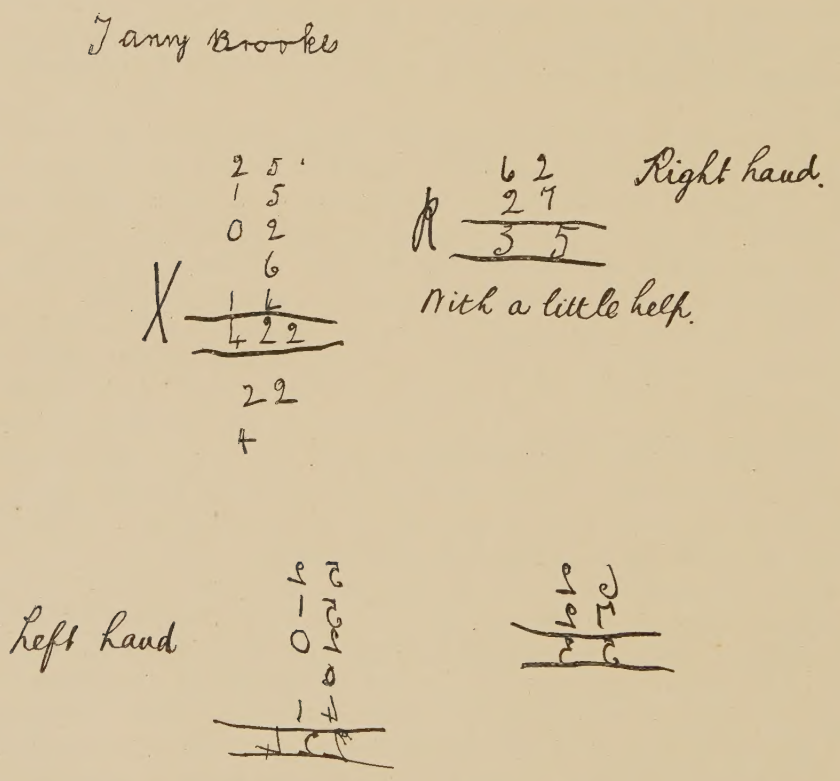
An interesting case is related by Poore,* in which the patient, on account of severe writer's cramp, learnt to write with his left hand,

* Poore, 'Electricity in Medicine and Surgery,' p. 205; also 'Med.-Chir. Trans.,' vol. lxi.

but was quite unable to write with the left hand without performing at the same time unconscious movements of the fingers of his right hand. It seems that here the cheiro-kinæsthetic centre for the left hand required reinforcement by impulses from the life-long trained centre for the right hand before the letters could be formed.

Elder,* quoted by Bastian, makes a very interesting observation in connection with mirror-writing. He found that in a series of 451

Fig. 2.

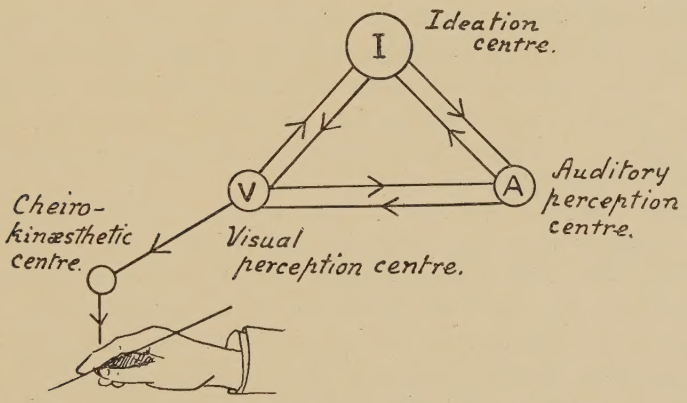


persons asked to write with the left hand, 23 wrote mirrorwise. He adds in this connection that the mirror-writing thus obtained shows an individual character similar to that of the right-handed caligraphy of the writer. In the specimen, Fig. 1, although the writing is undeveloped, a rudimentary individuality can be seen in the formation of the letters, and it will be noticed that the writing of the left hand is more free and the letters better formed than

* 'Berlin. klin. Woch.,' 1878.

that of the right. The girl had doubtless been taught to write her name with her right hand when attending the infants' school—an accomplishment which for various reasons is always taught as soon as a child can form his letters. That her ideation centre was active is a necessary corollary of the fact that she associated her personality with her name and with the word "Baby," and knew the combination of letter-symbols which represented them. She cannot be thought to have had a revived mental picture in her visual centre of her name written mirrorwise. We are therefore led to regard the cheiro-kinæsthetic centre as that sphere of the memory-complex in which the impulse towards inversion has its origin, and the question arises as to whether the use of the left hand is the cause or the result of this inversion.

Fig. 3.



It is a well-known and easily demonstrable fact that it is difficult without constant practice to perform different movements with each hand simultaneously, and that when this is attempted the movements of the limbs become the counterparts of each other. Thus in the writing of a European language the right hand has been trained to move from the left to the right, but a similar movement of the left hand would be from right to left, as will be seen at once if an attempt is made to write with the left hand. It seems, therefore, a reasonable hypothesis to suppose that in mirror-writing when the pen is taken into the left hand and an attempt is made to write therewith, the muscular movements are the result of impulses from the motor centre which co-ordinates the movements of the left hand, but that these are reinforced and overlaid by a train of motor-memory impulses from the cells of the cheiro-kinæsthetic centre for

the right hand in which they have been accumulated during the process of learning to write.

This explanation may serve to explain the fact that mirror-writing is generally found in young children, and is in the majority of cases a transitory phenomenon which disappears as the right hand becomes more and more facile in the use of the pen.

It is difficult to make any definite statement as to the frequency of the occurrence of mirror writing, but it is not as rare as is generally supposed. On making inquiries at a deaf school two ambidextrous deaf-mutes were found who wrote mirror-wise when using the left hand. In each of three schools for mentally defective children a mirror writer was discovered. On the other hand, in a school for physically defective children, where there were several cases of paralysis involving the right hand, in every case the left hand writing was rectigrade, a fact which appears to support the explanation of mirror writing given above, for in these cases, as the right arm has been paralysed before any education has begun, the motor-memory centre associated with the right hand movements has not received any training and therefore remains functionless. The process of writing is thus carried out solely by the functioning centres for the left hand.

Ireland ('Brain,' vol. iv, p. 361) quotes several instances of mirror writing associated with mental defect, and describes an interesting case of a school-boy, aged 13 years, of good intelligence, who used his left hand in preference to his right, owing, in all probability, to some partial paralysis of the right side which was more apparent in the right leg than in the right arm. When ordered by his teacher to write with his right hand he secretly used his left, a subterfuge which resulted in a page of mirror writing which the boy appeared to imagine was an accurate reproduction of the "copy." The lad could read his own reproduction with ease. In the 'Proceedings of the Psychical Research Society' (pt. xlix, p. 402) is a description of a case of multiple personality in which, during the emergence of certain personalities denoted by Dr. Wilson as B_2 and B_9, the writing (of which plates are given) was of a childish character, and though written with the right hand with ease and with ordinary rapidity was from right to left, but was not mirror writing. In this personality she could not write to dictation but could copy. She had no power of associating objects with their names, and exhibited a reversal of colour naming, describing the colours by their complements, red as green for example, black as white, and *vice versâ*. In this state, which was associated with

a cataleptic condition, she appeared to be intellectually a child of three or four. B_9, in which she called herself "Wicked creature," was associated with destructiveness, and on one occasion she made an attempt to put her smaller sister on the fire. In B_6, however, as "Good creature," she wrote a well-formed hand in the normal way, had no motor paralyses, and was a docile and domesticated girl. On the other hand, the personality denoted as B_{10} was that of an imbecile, paralysed, blind, deaf and dumb, yet the drawings which were executed during this state show that the ideation centre and the cheiro-kinæsthetic centre were even more active than before, for she was able to draw with considerable imagination and power of imagination, although the eyes appeared to be absolutely insensitive to light. It will be noticed that the characteristic attributes of the varying personalities which were associated with mirror writing in this case present a remarkable similiarity to those moral characters or deficiencies which are frequently found associated with mental degeneracy. A discussion, however, of this case would lead us too far from the subject of mirror writing.

A NOTE UPON THE POSITION OF THE APEX-BEAT IN CHILDREN.

By James E. H. Sawyer, M.A., M.D.Oxon., M.R.C.P.Lond.,
Assistant Physician to the General Hospital, Physician to Out-patients, the Children's Hospital, Birmingham.

The following investigation was undertaken in order to ascertain more definitely the position of the apex-beat in children. It is generally recognised that the apex of the heart is not in the same position in children as it is in adults, and that at some time during childhood it gradually assumes the position found in adults. In order to make our knowledge more definite upon this point the position of the apex-beat was noted in 500 children, who were examined in the out-patient departments of the General and Children's Hospitals, Birmingham. They were examined consecutively, and the best developed children were not picked out for the observations, so the results that are here recorded have been ascertained in children of varying types of development. No cases are included in which any disease of the heart or lungs was found,

nor those suffering from any malady which could displace the position of the heart. The children were all examined in the erect position, for it is well known how easily the heart is displaced in young children by change in position. In some of the children, especially under two years of age, the apex-beat was found in the fourth left intercostal space; these were not many and have not been included.

This investigation chiefly deals with the position of the apex-beat in relation to the left mammary line in the fifth intercostal space, and the cases have been classified as—(1) those in which the apex-beat was outside the mammary line, (2) those in which it was in the mammary line, and (3) those in which it was internal to the mammary line. The last cases are those which are considered to represent the adult type with regard to the position of the apex-beat. A more detailed classification was attempted at first, but was soon found to be impracticable.

A few points became obvious when this investigation was commenced, and were confirmed as the examination proceeded. In children under two years of age the position of the apex-beat was often very difficult to ascertain. It often could not be felt, even when the child was quite quiet. In some cases in which it could be located when the child was quiet it was impossible to feel when the child cried, as so often happens when an infant is undressed for examination. The mammary line was determined by the position of the left nipple, and one could not but come to the conclusion that the position of the nipples is relatively further out in children under two years of age than in older children. If this be the case the apex-beat in children under two years of age is relatively further out than is indicated in the accompanying tables. It was decided, however, in spite of this observation, to take the nipple as indicating the point through which the mammary line should pass, and not to try to draw an imaginary vertical line from the middle of the clavicle, for this seemed more difficult to do than in adults. On account of these considerations the curve in Chart 1 is probably not quite accurate, for if the mid-clavicular line were taken in place of a vertical line passing through the left nipple, the percentage of cases with the apex-beat outside would certainly be higher in the first two years of life.

The following table gives the actual number of cases examined in each year, the sex of the children, and the position of the apex-beat.

The Position of the Apex-Beat in the Fifth Left Intercostal Space with regard to the Mammary Line.

	Outside.			In			Inside.			All the cases examined.		
	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.
Under 1 year .	10	6	16	4	5	9	1	0	1	15	11	26
1– 2 years .	14	19	33	11	4	15	0	0	0	25	23	48
2– 3 „ .	11	6	17	13	12	25	0	0	0	24	18	42
3– 4 „ .	2	4	6	9	24	33	0	0	0	11	28	39
4– 5 „ .	5	4	9	18	12	30	0	1	1	23	17	40
5– 6 „ .	2	4	6	17	25	42	0	2	2	19	31	50
6– 7 „ .	1	4	5	14	20	34	4	3	7	19	27	46
7– 8 „ .	1	1	2	13	24	37	5	1	6	19	26	45
8– 9 „ .	1	2	3	6	15	21	5	3	8	12	20	32
9–10 „ .	0	0	0	10	14	24	10	5	15	20	19	39
10–11 „ .	0	2	2	2	10	12	6	8	14	8	20	28
11–12 „ .	1	3	4	6	5	11	6	3	9	13	11	24
12–13 „ .	0	0	0	4	2	6	4	3	7	8	5	13
13–14 „ .	0	1	1	3	4	7	4	4	8	7	9	16
14–15 „ .	0	0	0	2	2	4	7	1	8	9	3	12
	48	56	104	132	178	310	52	34	86	232	268	500

It will be noticed that there are not many cases recorded of children over twelve years of age. This is due to the fact that children are not admitted to the Children's Hospital over this age, and as the period over which the children were examined was the same at the two hospitals, it naturally follows that the number of the younger children is larger. The difference between the sexes with regard to the position of the apex-beat is only slight, but there is this one exception: Many more boys than girls were found to have the apex-beat within the mammary line, namely, 52 to 34, and this difference is more marked when it is noticed that thirty-six more girls were examined than boys. This seems to suggest that the apex-beat assumes the normal adult position earlier in life in boys than in girls.

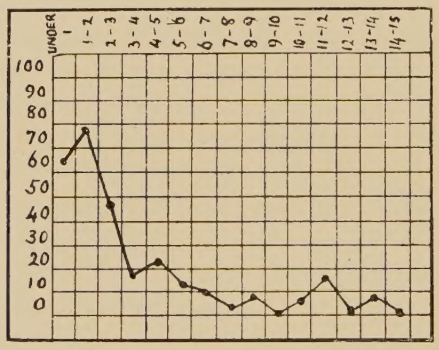
In order to ascertain what is the usual position of the apex-beat in each year of childhood the following charts have been constructed, in which is given the position of the apex-beat with regard to the percentage of the cases. Thus in the first year of life the apex-beat was found without the mammary line in 63 per cent., in the mammary line in 34 per cent., and within it in 3 per cent.

Chart 1 shows very definitely that the apex-beat is outside the

mammary line in between 60 and 70 per cent. of all the children examined in the first two years of life, and that up to the third year the apex-beat is in the same situation in half the cases. After the third year the number of cases with the apex-beat outside the mammary line suddenly becomes small, and gradually becomes less until at the ages of fourteen and fifteen years it was not found outside in any child whose chest could be considered normal. For the reasons pointed out earlier in this paper the cardiac apex is probably more often further out in the first two years of life than the curve in the chart would seem to indicate. If another method could be devised for determining the position of the apex the percentage of cases would certainly be higher during this period.

Chart 2 indicates that the apex-beat is commonly situated in the

CHART 1.



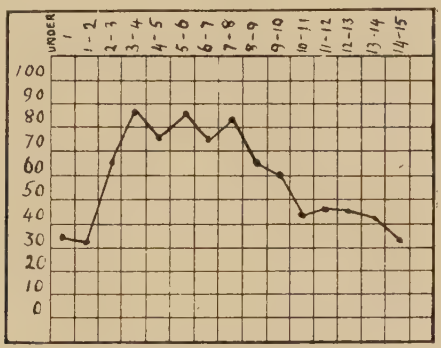
Apex-beat outside mammary line.

mammary line from the second to the end of the tenth year, and that after this age it gradually becomes less common in this position. Even between fourteen and fifteen years of age the apex-beat was in the mammary line in over 30 per cent. of all the cases examined. Between three and eight years the percentage of cases with the apex-beat situated in the mammary line was extremely high, namely about 80 per cent.

If all the children who were examined had been well developed, I feel sure that a larger number of them would have had the apex-beat within the mammary line at the age of fifteen years. The chests of many of the children between ten and fifteen years were poorly developed, and resembled more the infantile type, the antero-posterior diameter being relatively increased and therefore the chests narrower than is normal between these ages. In children with well-shaped

chests the apex-beat will be found not nearly so frequently in the mammary line after ten years of age as seems to be indicated in Charts 2 and 4, and these charts would probably be more correct if the line after ten years of age gradually fell to 0 at fifteen years.

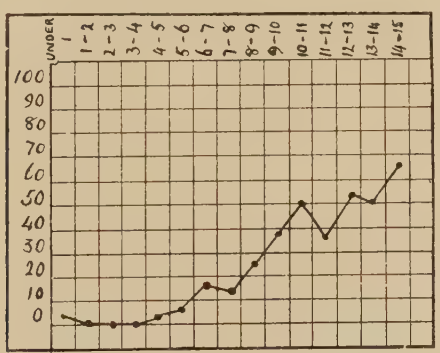
CHART 2.



Apex-beat in mammary line.

Chart 3 shows very clearly that it is extremely rare to find the apex-beat internal to the mammary line in the first six years of life, and that it is not until the tenth year that the apex-beat appears in this situation in half the cases.

CHART 3.

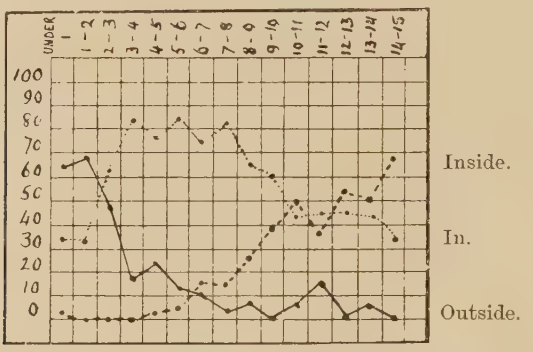


Apex-beat inside mammary line.

The conclusion that may be arrived at from this investigation is that the apex-beat is normally situated without the mammary line up to the third year, in the mammary line from the third to tenth year, and that after this age it gradually assumes the position found in the adult. Even at the age of fifteen years the apex-beat is

found in the mammary line in almost a third of the cases, but this large percentage is probably due to the bad development of the chest in many of the children.

Chart 4.



Combined chart showing percentage of cases with apex-beat inside, in, and outside the left mammary line.

That the apex-beat of children is situated further out than in adults is generally recognised, but it is not usually accepted that this outward position remains during such a long period of the child's life.

The Royal Society of Medicine.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

Friday, November the 26th, 1909.

Dr. J. Porter Parkinson *in the Chair.*

CASES.

Multiple Peripheral Neuritis in a Child, by Dr. A. E. Garrod. Girl, aged 8 years, healthy till March, 1909, when she had an attack of abdominal pain and passed a motion containing several ounces of blood. A similar attack occurred in May. In August the pain became constant. Loss of power in the upper and lower extremities developed in September. There was no history nor evidence of diphtheria, and examinations of the urine and hair for arsenic and of the urine for lead and hæmatoporphyrinuria were negative. The fundi were normal.

Dr. Garrod said he had not any idea as to what was the nature of the poison at work producing the peripheral neuritis; he refrained from suggesting such shadowy things as intestinal toxins, etc., which was apt to be invoked as a refuge of the destitute. He was prepared to hear some contend that the case should be ranked as anterior poliomyelitis rather than

one of peripheral neuritis, and he did not know that he could give any definite ground for excluding the former diagnosis. His diagnosis rested on having watched the case for several months and on the opinion of Dr. F. E. Batten, which he much valued.

Dr. G. A. Sutherland regarded the case as one of very special interest, but he did not think members would be able to throw much additional light on the subject, for minute examination had been made. He thought time would throw much light on the question of anterior poliomyelitis. If it were that disease there would be an affection of certain muscles. Last year he had a somewhat similar case, in which a final diagnosis was never reached. The paralysis came on rather suddenly and the child was absolutely paralysed in extremities and trunk. The anterior abdominal muscles on the left side were paralysed and the breathing was done by the right side of the chest. The patient continued in that condition for a long time, but there was gradual recovery. Some weakness, however, was remaining in the left leg. There was also much wasting and the child had not been able to walk properly, and now there was some spinal curvature. In some of those cases it was practically impossible to tell during the illness what the lesion was, whether it was peripheral nerve trouble or a spinal lesion.

Dr. E. I. Spriggs rose, not because he could throw any light on Dr. Garrod's case, but to mention that two cases were shown at the last meeting of the Section which illustrated what Dr. Sutherland had just said. They were cases of anterior poliomyelitis affecting all four limbs. Already it was easy to distinguish a difference in the rate of improvement in different muscles.

Dr. Garrod replied that there had never been the slightest evidence of any discrimination with regard to particular groups of muscles, and that was one of the impressions which had led him to lean towards the diagnosis of peripheral neuritis.

Achondroplasia in a Twin, by Dr. R. Hutchison. One twin, a girl, aged $1\frac{1}{2}$ years, was a case of well-marked achondroplasia; the other twin, a boy, was healthy.

Cirrhosis of Liver, by Dr. R. Hutchison. Girl, aged 9 years; swelling of abdomen one year. No previous illness of importance. Two still-births preceded this child. Snuffles in infancy. Liver enlarged and irregular; spleen considerably enlarged; some ascites. Cirrhotic facies.

A Case of Unidactyly, by Dr. R. Hutchison. Boy, aged 13 weeks. One digit only on hands and feet, otherwise normal. First child of this generation. The father and his two brothers and one sister are similarly affected; so were his grandfather and his mother. A daughter of the father's sister exhibits this condition.

The Chairman, discussing the case of cirrhosis of the liver, said that one of the most interesting points which were mentioned by Dr. Hutchison was the curious way in which congenital syphilis, as well as other things, selected one organ, apparently, for its operations. He remembered one child which had disseminated choroiditis but no other evidence of syphilis, but the other children were typically syphilitic. He had seen a case of paroxysmal hæmoglobinuria with the same. Other diseases, of course, did the same thing, such as rickets and lead.

Dr. Shuttleworth said he thought the cases of twins, one of whom was normal and the other abnormal, were extremely interesting and somewhat

puzzling. He showed two photographs of twins, which Dr. Jeffreys Wood, of Melbourne, sent him, in which one twin had all the characteristics of Mongolism and the other was healthy. It was hard to say why, with the same mother but different ova, one twin child should be normal and the other twin should be affected, either with achondroplasia or with Mongolism as in the case pictured there.

Dr. Eustace Smith remarked that one saw marked differences in twins even among children who were normal: one was vigorous and the other weakly. The question was whether that was not *ab initio*, from the stage of the ovum; the weakly child might always have had small resistance to toxins. The syphilitic poison was a matter which one might quote as having certain analogies. There were cases recorded of twins, one of whom had had from birth all the symptoms of inherited syphilis, whereas in the other up to a fairly good age there had been no sign of syphilitic infection. With syphilis one did not know what the later manifestations might be for a number of years. The case of unidactyly was to him truly remarkable, that there should be that defect, which one must consider was originally acquired, and transmitted in so many cases amongst three generations. It would be most interesting to bring the case under the notice of Professor Karl Pearson and others engaged in a statistical line of inquiry, because they gave a co-efficient of the probability of any defect being handed on; and he thought the present instance was in excess of any calculation which had been heard of in that direction.

Dr. Charles W. Chapman, referring to the case of unidactyly, said that at the Clinical Society a case was brought forward of a father and baby with that deformity of claw-hand. The child had deficiency of the radius of one hand. There was a full description in the Clinical Society's 'Transactions' for 1900.

Dr. G. A. Sutherland asked why Dr. Hutchison called Case 3 one of cirrhosis of the liver. Probably all would agree that the enlarged masses on the abdomen were specific; the spleen was also enlarged. The exhibitor said there was, or had been, some ascites, but he (Dr. Sutherland) could not find any at present. Also, What was the "cirrhotic facies"? He (Dr. Sutherland) regarded it as a case of multiple gummata of the liver, which were well known in connection with the late manifestations of hereditary syphilis. He believed that with care the child would recover.

Dr. A. E. Garrod said that in discussing such cases as the twins it was essential to draw a sharp line between true and false twins. One could not distinguish during life, except that they believed that twins who showed marked resemblance were true twins, *i. e.* came from one ovum. But in Dr. Hutchison's case they were false twins, *i. e.* from two ova; and it was not more remarkable that two such twins should differ than that two successive ordinary children should differ. But if one could find that achondroplasia occurred in a pair of one-ovum twins they could prove that achondroplasia was not strictly congenital, because one ovum would scarcely hold a normal and an abnormal one, but that it was an acquired characteristic *in utero*.

Dr. Hutchison replied that Dr. Garrod's point was a very important one. He had a photograph of twins, one of which was a cretin and the other quite normal, but there, again, they were false twins, and they were of different sexes. With regard to the case which he called "cirrhosis of the liver," he did not think one would get so much enlargement of the spleen in simple gummata of the liver. The spleen was nearly a hand's breadth below the

edge of the ribs. And when she came in there was an appreciable amount of ascites to be detected easily by the shifting dulness. He also attached considerable importance to the "cirrhotic facies," and was surprised Dr. Sutherland did not know what that was. He had always considered the facies a considerable help in diagnosis. The chief thing was the presence of spider-like telangiectases in the skin, and to some extent in the mucous membrane; and in grown-up persons there was a wasted and somewhat jaundiced appearance. The unidactyly cases were particularly interesting from a Mendelian point of view, and he hoped to have the matter worked up by Dr. Bulloch, of the London Hospital. The case mentioned by Dr. Chapman was a similar kind of deformity, also showing the hereditary tendency, but it did not affect so many generations as in his own cases.

Congenital Enlargement of One Limb occurring in Brother and Sister, by Mr. O. L. Addison. Boy, aged 9 years: Enlargement of right arm, shoulder, and hand; skin and subcutaneous tissues normal. Girl, aged 5 years: Enlargement of left leg; calf relatively much larger than thigh, and feels hotter than the rest of the limb.

Dr. Parkes Weber said he regarded the cases as half cases of hemi-hypertrophy. He had a very good reason for classifying them in that way. It was that there were other kinds of congenital enlargement of one limb, also developmental, but only one kind of such which corresponded to half a case of hemi-hypertrophy. The characteristic of those cases was that the limb was always increased in length, whereas in other enlargements of limb, especially those called "trophœdema," there was never any increased length of bones in the upper extremities. Another characteristic of the cases was that they were nearly always associated with angioma formation. In the boy now shown there was merely a little superficial telangiectasis. He believed that some of the enlargement of the leg was connected with enlarged veins, and possibly enlarged lymphatics. In the 'British Journal of Dermatology' for 1907 he published a paper on such cases, and collected records of every case he could find. He would now like to alter the title of such cases to "hypertrophy of one limb of the type of hemi-hypertrophy."

Mr. Lockhart Mummery expressed his disagreement with Mr. Parkes Weber's contention, because in the cases which had been seen that day and in many of the cases of gigantism of one limb there was plenty of evidence that it was the blood supply or the lymphatic system which was at fault. The boy showed marked alteration in the peripheral blood-vessels of the thigh, and the girl had telangiectases in the back, and much thickening of the soft tissues. In the hypertrophy the whole half of the body shared, including head, limbs, chest, epiphyses of bones, and tongue; and it was not conceivable that that could be due to any condition of the blood-vessels. There was no system of the body which was anatomically bilateral except the nervous system. In hemi-hypertrophy the only possible explanation seemed to be that the nervous system was affected; and there must be some central lesion.

Dr. Parkes Weber rejoined that in the paper he wrote he alluded to the abnormalities often found in the cases of hemi-hypertrophy connected with the blood-vessels; there was either some angioma formation, some telangiectasis, or something of the kind. Quite possibly those were due primarily to some nervous disorder, but that he did not regard as to the point. He believed that in one or two cases the brain on the opposite side was also hypertrophied, but that was not so in every case, Every degree

might be met with, affecting from one to four limbs, and affecting the face and the tongue.

Infantile Heart showing Nodules on Endocardium, by Dr. R. C. Jewesbury. The specimen was from a case of broncho-pneumonia in a child, aged 4 months. During life the cardiac dulness was not increased, and the heart-sounds were normal. Post-mortem: Numerous wart-like bodies were present, especially on the mitral and aortic valves; there were a few also on the tricuspid and pulmonary valves and on the septum of the foramen ovale. Microscopically there was a delicate connective-tissue substratum supporting a layer of epithelium. There were no signs of old or recent inflammation.

The Chairman said that occasionally those who had seen post-mortem examinations on young infants saw light vegetations of that sort; but the present ones were larger than any he had seen, and more numerous.

Dr. E. I. Spriggs said he thought the lumps must be regarded as a hypertrophy of the little nodules which they were warned not to mistake for vegetations in infants. They looked like it, and that was what he thought when he saw the specimen shortly after the post-mortem. Dr. Jewesbury had had the specimens examined, and obviously there was no conclusion except the one which had been mentioned. He, Dr. Spriggs, thought they were hypertrophies of the small connective-tissue tumours covered with epithelium which were in the hearts of young infants. It was interesting that they occurred on the septum between the auricles as well as on the mitral and tricuspid valves.

Compression of the Trachea by an Enlarged Thymus, by Dr. George Carpenter. The specimen was from a previously healthy male child, aged 10 months, who suddenly developed rapid and laboured respiration and died in less than twenty-four hours. Post mortem the thymus was found to extend in a solid mass from the thyroid gland to behind the manubrium, where it split into two lobes, the left and larger extending to the third costal cartilage, and the right to the second costal cartilage. The thyroid and parathyroids were also enlarged, but there was no general enlargement of the lymph-glands or lymph-follicles.

Dr. J. D. Rolleston, who showed the case for Dr. Carpenter, said the question of thymus death had for fifty years interested the medical profession. Many doubted the existence of a thymus death at all. Recently two remarkable papers had appeared, one in the 'Vierteljahrschr. f. gericht. Med.,' 1908, p. 88, by von Sury, of Vienna, who had had extensive experience of autopsies on children, and in 2341 autopsies of children up to 15 years at the Vienna Medico-Legal Institute he could not find a case where death could be attributed to thymus enlargement. He thought that in most cases death had been due to some other cause, such as enteritis or bronchitis. In the August number of the 'Archives of Pediatrics' Warthin criticised von Sury and believed many of the cases in literature justified the thymus death supposition. In favour of the mechanical cause of death was the fact that microscopical sections of the lung in this case had been examined by Prof. Keith at the Royal College of Surgeons, who reported that they showed an effusion of blood into the air-cells, thus giving evidence of suffocation.

Microscopical Section of the Liver of a Case of Icterus in an Infant, by Dr. George Carpenter. The section was from a girl, aged 5 months, who died after an attack of catarrhal jaundice. At the time of death the jaundice had disappeared. Microscopically the liver capillaries were filled with red blood-corpuscles, and there was disintegration of cells

in the neighbourhood of a few clusters of leucocytes. The bile-ducts and Glisson's capsule were normal.

The CHAIRMAN said in regard to Dr. Carpenter's first case that a point against the mechanical view was, How did the child live ten months with such a condition? If it was mechanical pressure the thymus was probably bigger at one month, and the thorax was smaller, so that the pressure would be greater at the younger age. Was there any evidence of an acute enlargement just before death? There were many causes in young infants which would cause rapid death, for instance, various kinds of glottic spasm or acute suppurative catarrh, which left practically no trace in the lungs.

Dr. THURSFIELD said he had been for some years interested in those questions. In the present specimen he did not see any evidence of compression of the trachea. Nor did the present thymus look like one which would cause death. By thymus death he meant death occurring in cases of enlarged thymus with evidence of lymphatism; whereas here it seemed to have been used in the sense of death from mechanical compression. He thought the cause of death in the present case should be sought elsewhere. Were any cultures made from the heart's blood? Or did the lung, in the fresh state, show evidence of broncho-pneumonia? One case which would carry conviction as one of compression of the trachea was that published by Dr. H. D. Rolleston ten or fifteen years ago, in which the thymus was of enormous weight.

Dr. J. D. ROLLESTON* said he could not answer the Chairman's question; Dr. Carpenter and he were discussing it, and they could not satisfy themselves about it. He certainly thought the trachea was flattened. It was another point whether the flattening was due to the thymus. Von Sury said there were some cases of flattened trachea where the flattening was not due to an enlarged thymus. No cultures of the blood were taken. There was no evidence of broncho-pneumonia in the lung in the fresh state.

Congenital Malformation of Heart showing Complete Atresia of the Pulmonary Artery, by Dr. A. C. D. FIRTH and Dr. E. I. SPRIGGS. Child, aged 18 weeks. Cyanosis was persistent during life and was not improved by oxygen. Nothing abnormal in the heart was detected during life, except that the second sound was more audible at the right border of the sternum. The red corpuscles numbered 6,800,000. The muscular wall of the right ventricle was much thickened. Both ventricles communicated through a hole in the upper part of the interventricular septum. The pulmonary artery was represented by a thin-walled vessel terminating blindly at the base of the arterial trunk. The right auricle was much dilated, the left extremely small, and the foramen ovale was patent.

The CHAIRMAN said he had treated some cases of congenital heart disease with oxygen, but, as far as he could make out, with no benefit at all.

Dr. THURSFIELD asked whether Dr. Spriggs had ever seen cyanosis of any kind in an infant or adult relieved by oxygen.

Dr. SPRIGGS: Yes.

PAPER.

A Case of Strangulation of the Small Intestine by a Band in a Child, aged 15 months, by Mr. P. LOCKHART MUMMERY.

* The specimen was submitted to a further examination at the Royal College of Surgeons by Prof. Keith, and on opening the trachea it was found to be lined with false membrane. This was invisible from the larynx and did not extend into the bronchi. Although the stenosis of the trachea was not, therefore, the actual cause of death from suffocation, it in great measure conduced to it.—G. C.

Philadelphia Pediatric Society.

Meeting, November the 9th, 1909, J. Claxton Gittings, M.D., President.

SYMPOSIUM ON SCARLET FEVER.

(1) **Ætiology of Scarlet Fever.**—Dr. Alfred Hand, jun., gave a brief historical sketch of scarlet fever, quoting a description of the disease from Smetius (1611), who, however, did not name it. Sydenham (1624–1689) being the first to differentiate it from measles and smallpox, and to name it *febris scarlatina*. Charts were exhibited giving some statistics for Philadelphia, one showing that the monthly number of cases bears a close relationship to the school-term, July, August, and September having about 100 cases each, while from October to June the number ranges from 200 to over 300 a month. Another chart showed that there is a lowering in the incidence of the disease during the last five years as compared with the four years preceding, but that there has been an increase in the mortality from 2·9 per cent. in 1905 to 5·2 per cent. in 1907. A third chart showed the annual fluctuations in the actual number of deaths since 1862; this also illustrating the variations in severity of different epidemics; the highest points were reached in 1870 and 1875 with 956 and 1032 deaths respectively, while 1872 had only 174 deaths in comparison; 1896 had 61 and 1897 had 282 deaths, the lowest number of all being reached in 1905 with 57 deaths.

While some investigators believe that a streptococcus is the exciting cause this belief is not yet generally accepted, and it is of great importance to have this point settled. When the specific cause is discovered beyond doubt it will clear up many strange features of the disease as to its modes of travel and, perhaps, as to the variations in susceptibility to it, and in the mortality in different epidemics; but it will be of the greatest help in diagnosing the mild and atypical cases.

(2) **The Municipal Control of Scarlet Fever.**—Dr. Maurice Ostheimer read this paper explaining the regulations of the Philadelphia Board of Health in preventing the spread of scarlet fever. Post-cards are distributed on which the physician is required to report each case as soon as diagnosis is made. On receipt of this card a medical inspector is sent to the home of the patient to place placards on front and back entrances, and to see that the patient be properly isolated. No case of scarlet fever is allowed to remain on the first floor of the ordinary Philadelphia house. If not properly isolated, with trained nurse or other competent woman, who remains in the sick-room with the patient, the premises are placed under police quarantine, an officer being stationed front and back, allowing no one to enter or leave. No empty milk bottles are permitted to leave the house until disinfected. Wage-earners are allowed to move to homes in which there are no young children, after taking a carbolic bath and having their clothing disinfected. Children are excluded from school and Sunday school so long as the house remains placarded. The sanitary condition of the premises is inspected, and unvaccinated individuals are urged to submit to vaccination. All inmates of houses in which scarlet fever exists are prohibited from working in any establishment for the manufacture or sale of wearing apparel, upholstery, house-furnishings, bedding, cigars, cigarettes, or food-stuffs. The medical inspector notifies employers of scarlet fever occurring in the families of their

employees; he excludes employees from work and permits their return after removal and disinfection. A sterilised gown is left at each house by the Board of Health for the attending physician to wear when visiting his patient.

The medical inspector also sends a post-card to the attending physician on the day he placards the premises, which the attending physician returns to the Board of Health when the case is ready for disinfection. On receipt of this card the medical inspector visits the house, sees the patient, and if satisfied that desquamation is over and that there is no discharge from nose or ears, he orders disinfection with removal of the placards on the next day, provided that at least twenty-one days have elapsed from the onset of the disease He then sends school children back to school and notifies milkmen that milk bottles have been disinfected.

If isolation should be impossible at home, the patient is removed to the Municipal Hospital for Contagious Diseases. A telephone call will bring the ambulance at once. Disinfection of the premises follows one day after removal of the patient to the hospital, but school children are excluded for a week at least. The diagnosticians of the Board of Health are always ready to see any doubtful case and to make the diagnosis.

(3) **Difficulties in the Diagnosis of Scarlet Fever.**—Dr. Jay F. Schamberg discussed various difficulties in the diagnosis of scarlet fever. He believed that more errors of diagnosis were made in connection with this disease than with any other acute infection. In formulating the diagnosis undue weight should not be given to any one symptom; all of the associated phenomena should be carefully considered. Dr. Schamberg regarded the coincidence of a distinct angina and a well-pronounced scarlatinoid rash as not only warranting the diagnosis of scarlet fever, but, in view of our duty to the public health interests, this association compels us to regard and treat such cases as scarlet fever. He strongly counselled against the administration, to patients suffering from tonsillitis, of any drugs capable of producing a scarlatinoid erythema. Among these he particularly mentioned quinine, the salicylates, chloral, mercury, belladonna and veronal. Dr. Schamberg stated that in his opinion too much diagnostic importance was attached to desquamation. The orderly progression of the desquamation, its long persistence and certain special characteristics were considered of more weight. Many scarlatinoid erythemas due to drugs and various toxic conditions cause peeling of the skin, some of them even more pronounced than that observed in scarlet fever.

(4) **The Complications of Scarlet Fever.**—Dr. S. S. Woody discussed as the complications of scarlet fever otitis and mastoiditis, nephritis, arthritis, ulcerative stomatitis, tonsillitis, adenitis, broncho-pneumonia, rhinorrhœa and relapses, giving many interesting details from his large service in the Municipal Hospital for contagious diseases.

(5) **The Treatment of Scarlet Fever.**—Dr. D. J. M. Miller read this paper. He urged against over-treatment, saying that often the issue is unfavourably affected by it. He advocated a minimum amount of milk in the diet, because of its high protein content and its tendency to provoke digestive disorders. It should be diluted with and substituted by gruels and cereals, with vegetable soups and fruits. Animal broths he considered as objectionable as meat, but in prolonged cases, with loss of weight and

anæmia, he would not hesitate to give meat. The patient should remain in bed five or six weeks, even in the mildest cases. He believed that less nephritis occurred and the patients were more easily managed by this method. Daily sponging was advocated, but inunctions were postponed until desquamation occurred, because they interfered with the excretory action of the skin. He deprecated the use of carbolic acid, as poisoning has occurred from its use. Physicians who did not examine the urine daily failed in their duty. The use of drugs was entirely symptomatic; alcohol should be limited to septic cases; weak first heart-sound requires strychnia, camphor, caffein; digitalis is questionable; anæmia needs iron hypodermatically; excessive temperature and temperature continuously above 103° F. is best controlled by hydrotherapy, bearing in mind the young child's susceptibility to cold. So, too, are restlessness and nervousness, combined with nerve sedatives. The throat should be cleansed daily with antiseptic washes, the nose with cotton swabs; because of danger to the ear douching and spraying were condemned. The ears should be examined daily; bulging of the tympanic membrane called for immediate incision.

Dr. Miller also went over treatment of the many complications in detail, and concluded with the statement that the serum treatment was still *sub judice*.

Discussion.

Dr. W. M. Welch said that the period of incubation of scarlet fever, while usually short, may be variable. He believes that in the majority of cases this period is four or five days; from three to seven days will cover most cases. The specific cause of the disease remains unknown. The susceptibility in individuals varies not infrequently. He cited the instance of a nurse who had been on duty in the scarlet fever wards for about three months and was considered immune, left the hospital, and was absent a year. On her return to duty in the scarlet fever ward she contracted the disease in a severe form. He stated that the disease is most frequent in young children, and is also most fatal among them. Many persons appear to be naturally immune. While as many as four fifths of the students who annually visit the Municipal Hospital for clinical instruction have never had scarlet fever, only one case has developed among them in the past ten years. The onset is sudden. Sore throat is the earliest symptom, and this is rarely absent. The rash makes its appearance in from six to twenty-four hours from the beginning of illness. It prefers the trunk and extremities; frequently it is absent on the face. But whether the face be involved or not it almost always presents an appearance that is peculiar—circumoral pallor with intensely red lips. The eruption is diffuse and punctiform; frequently miliary vesicles are seen on parts where the rash is intense. Stroking the skin of the trunk and extremities will cause pale lines to appear. These will rapidly disappear by return of the capillary circulation, but in a few moments the pale lines reappear and continue for some time. This is commonly called "secondary pallor." The appearance of the tongue is undoubtedly of much importance. At first it is covered with a creamy-white coating, while its edges and tip are of bright red colour and the papillæ very prominent. On the third day the coating will be seen to have disappeared to a great extent, and on the fourth day its disappearance is usually complete, leaving the upper surface of the tongue very red and the papillæ very prominent. We now have the strawberry tongue well marked. He regards the form of desquamation which begins at the free margins of the finger-

nails and strips backward, leaving the ends of the fingers of a pink colour, as most characteristic. Dr. Welch confesses that he is unable to say when a person who has recovered from scarlet fever is free from danger of spreading the disease. He has known such persons to communicate the contagion for as late a period as four months from the beginning of the illness, and long after all evidence of desquamation had disappeared. He is unable to state positively that the exfoliating particles of the epidermis are not infectious, but he firmly believes that the discharges from the nose, throat, and ears are infectious, and that they may continue so for a long time. In speaking of treatment, he favoured the use of chloral hydrate where there is delirium with insomnia and restlessness. In scarlatinal nephritis he highly recommends infusion of digitalis with acetate of potash. Should the urine continue scanty recourse should be had to copious sweating by means of the hot pack.

Dr. B. H. Potts said that a very considerable percentage of his patients give a direct scarlet fever history. This is true not only of suppurative cases but also of many patients who suffer from increasing deafness without history of any ear discharge, though there may have been discharge, with membrane rupture without the patient's knowledge, the scars on the membrane giving indisputable evidence of the process. Otitis media is the most common and the most dangerous complication of scarlet fever, on account of the possibility of grave septic conditions resulting. Function is nearly always impaired and frequently destroyed. The streptococcus is the micro-organism most frequently present in discharges from the ear. Dr. Potts divides cases of scarlatinal otitis into three classes occurring at different stages of the general infection. The first is acute serous inflammation developing before the eruption, mild in form, with few symptoms and a serous discharge, which may later become infected. The second class, acute suppurative otitis, generally begins about the second week of the illness, with a rise in temperature, pain and adenitis. The third class is the neurotic type, very severe in character. Dr. Potts believes that infection occurs sometimes through the Eustachian tube and sometimes through the blood and lymphatics. Prognosis should be guarded. Patients with enlarged tonsils and adenoids are apt to suffer severely and to have continued discharge. Treatment is surgical and antiseptic. There is unquestionably a contagious element in the discharge of a scarlatinal otitis, and great care should be exercised in the antiseptic cleansing of the ear. The discharge should be considered a factor in quarantine. Early recognition and prompt treatment of ear complications will certainly save your patient trouble and distress and may save a life.

Dr. E. E. Graham said that scarlet fever is not very contagious during the first twenty-four hours. This is proven by the fact that children isolated promptly at the end of the first twenty-four hours very often do not contract the disease. This is probably due to the fact that contagion is not spread by the breath, and during the first twenty-four hours there is not so much membrane and discharge from the various mucous membranes. There is, of course, no desquamation, and there is probably little if any infection of urine, fæces or perspiration; or if there is such infection, it is probably less than later in the disease. Too much stress cannot be laid on the importance of isolating cases of scarlet fever as long as there is any purulent otitis, rhinitis, pharyngitis, or suppuration of the glands. All children before admission to a hospital should be carefully examined to ascertain if any such condition, should it be found, might not be a sequel to

scarlet fever. The discharge of post-scarlatinal empyema is also positively capable of transmitting the disease. A scarlatiniform rash alone is not scarlet fever, for digestive disturbances in infants not uncommonly produce an erythema closely simulating scarlet fever, as also may result from antipyrin, quinine and belladonna. Sore throat with rash should always suggest scarlet fever. The temperature chart is important in diagnosing complications. Dr. Graham advanced several arguments against the streptococcus being the cause of scarlet fever. He also advocates nasal douching in the treatment of scarlet fever.

Dr. F. C. Knowles emphasised the resemblance between certain drug eruptions and scarlet fever, particularly in regard to quinine. Several cases of this character had been observed. Two years ago he saw a patient in Dr. Davis's service at the Pennsylvania Hospital, in whom several days elapsed before the diagnosis of quinine dermatitis could be made positively. Recently a patient under treatment for exfoliation of the palms of the hands and fingers, resembling markedly that found in scarlet fever, was found to be due to packing quinine pills in boxes and bottles. Several cases of exfoliation of the hands associated with sweating have been observed of the type mentioned by Dr. Schamberg in his paper, and previously reported by him in the 'Journal of the American Medical Association.'

Dr. J. T. Rugh spoke of the joint manifestations of scarlet fever. They may result from the toxins elaborated or from the direct infection of the joint with the streptococcus. Surgical intervention should be used very early in those cases due to direct infection to save the joint function if possible and often to save life, as these inflammations are extremely violent.

Dr. Miller remarked that nothing had been said in reference to the duration of quarantine in cases with the enanthem alone, as Forchheimer calls those occasional cases with throat and general symptoms but without eruption. Dr. Miller thought such cases should be isolated until the possibility of desquamation had passed two or three weeks.

Dr. Schamberg added that there was no positive evidence of the infectiousness of desquamating epithelium in scarlet fever, and there was considerable negative evidence against the view generally held. The majority of physicians of large experience no longer hold to the traditional view on this subject. Despite this, the establishing of the cessation of desquamation as the minimum boundary of the isolation period was not a bad working rule. The real lurking places of the germs are doubtless the nose, throat and ears.

Reports of Societies

MIDLAND MEDICAL SOCIETY.

November the 17th, 1909.

Mr. Frank Marsh, *President, in the Chair.*

A Case of Congenital Malformation of the Nails of the Fingers and Toes.—Mr. Billington showed a girl, aged 3 years, who suffered from a peculiar form of keratosis, which was first noticed at the age of 3 months.

She was the sixth of a family of seven, the rest being normal. The fingers and toes were perfectly natural and showed no trophic changes, but each nail of the fingers and toes looked like the claw of a dog. A horny mass like a spur black in colour, and very hard, arose from the whole of the surface usually occupied by the nail, and curved over the end of the digit, projecting some distance. The child had been brought to the Queen's Hospital in order to have the nails cut.

A Case of Cirrhosis of the Liver.—Dr. EMANUEL showed a girl, aged 4 years, who had an enlarged cirrhotic liver and spleen and a slight amount of secondary anæmia. There was no ascites. The condition was first noticed three and a half months ago, when the child came under observation for an attack of catarrhal jaundice lasting about fourteen days. Under anti-syphilitic treatment the liver and spleen had not diminished in size, and there were no other signs of syphilis present. The question of the condition being due to alcohol was also discussed; there was reason to believe that the child had been allowed to take small quantities of beer, although it was impossible to compute how often this had occurred.

A Case of Syringomyelia.—Dr. KAUFFMANN showed a girl, aged 15 years, suffering from syringomyelia of seven years' standing. The right pupil and palpebral fissure were smaller than on the left side, and there was very marked kyphosis of the cervico-dorsal region, coupled with scoliosis below. No trophic joint lesion was present, but there was a great tendency to almost painless sores on the right arm and leg and on the right buttock. The onset and progress had been gradual, and there had been no pain at any time.

A Case presenting many Rheumatic Nodules.—Dr. SAWYER showed a boy, aged 18 years, who presented numerous rheumatic nodules. The boy was suffering from chorea, which he had had on many occasions since the age of six years, and in March, 1909, he had an attack of acute rheumatism, during which endocarditis of the mitral valve developed. The rheumatic nodules made their appearance two months later. The largest were on the backs of the hands, and were about the size of an almond. There were a few small ones on the fingers, and rows of shot-like nodules along the tendons on the anterior surface of each wrist. Nodules were also present on the elbows, knees, dorsum of the feet, ankles, and over the right parietal bone. None of them were tender, and they varied considerably in size from day to day, usually being larger in the evening, when there was a slight rise in the patient's temperature. The chief points to be noticed were: (1) The unusually large number of the nodules, (2) the long time they had existed, and (3) their presence in so old a patient.

A Case of Intra-thoracic Obstruction in a Child aged 4 years.—Dr. DOUGLAS STANLEY showed a boy who had had signs of intra-thoracic pressure of nine months' duration. There was a large amount of œdema of the face and eyes, engorgement of the superficial veins of the neck, thorax, and abdomen, in which the blood-flow was from above downwards. On percussion of the chest there was absolute dulness all over the sternum, and this extended about two inches each side of the sternum. The liver reached upwards to the fifth rib in the right mammary line, and extended about a finger's breadth below the costal margin. There were signs of consolidated

lung at the right apex. There was also a spasmodic cough. At first the cause of these symptoms was thought to be a sarcoma of the thymus, but there had been such marked improvement in the course of some weeks that this diagnosis was no longer probable. Possibly the condition was due to tuberculous glands.

Review of Book.

A Guide to the Feeding of the Infant During the First Year. By J. W. Simpson, M.D., F.R.C.P.Edin., Assistant Physician, Sick Children's Hospital, Edinburgh. Price 2*s.* net. Edinburgh: James Thin. London: Simpkin, Marshall, & Co., 1908.

This little book of 80 pages is devoted to the feeding of the infant during the first year of life, and to some of the disorders which arise as the result of improper feeding. It is divided into two parts, and inserted between them is a short and useful chapter on the proper way to wean the infant. Part I, which deals with breast feeding, is written in a clear and concise manner, and is perhaps the best portion of the book. The author points out clearly the necessity for regular feeding, the length of time the infant should be allowed at the breast, and the common causes which tend to upset the child's digestion. The composition of breast milk is included and the evidences and causes of unsatisfactory breast-feeding discussed. The treatment of weakly and premature children, the diet of the nursing mother, the care of the nipples, and the contra-indications to maternal nursing are also described.

Part II deals with artificial feeding, and is clearly written. After comparing the composition of human and cow's milk, the most satisfactory manner of artificial feeding from the time of birth is shown, and the various mixtures which may be given to the child are described, with the indications for their use. The more common causes of gastro-intestinal disturbances in infancy, such as vomiting, colic, constipation and diarrhœa, are given, and their treatment, both preventive and curative, clearly outlined. In some of the tables on artificial feeding the names of certain well-known patent foods appear. Patent foods are not necessary for a healthy child, and certain of these foods should not be picked out for advertisement in a medical book while others which are quite as good are omitted. It would perhaps have been better not to have mentioned at all any patent food, and we are surprised that the author should have done so, for he states earlier in this work, "It is the unanimous opinion of the doctors who have devoted most time and work to this special subject, that patent foods are, generally speaking, injurious to the infant, and that they should be used only after the most careful consideration, and always on medical advice."

Each part of the book is divided up under certain headings, which facilitates reference to any particular point. This book should certainly be useful to the younger practitioners of medicine, and to medical students, and should serve as a valuable guide to mothers of average intelligence, for it has been written in a popular manner and is therefore easy for them to understand. We can thoroughly recommend this book as a reliable guide to infant feeding during the first year of life.

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